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SUPREME COURT OF THE UNITED STATES

October Term, 1991

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.,
Petitioners and Cross-Respondents,

v.

ROBERT P. CASEY, et al.,
Respondents and Cross-Petitioners.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF THE AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS (AAPLOG) AND THE AMERICAN ASSOCIATION OF PROLIFE PEDIATRICIANS (AAPLP) AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI

Petitioners and the American College of Obstetricians and Gynecologists (ACOG), in its brief *amicus curiae* in support of petitioners, have provided this Court with a radically one-sided view of pregnancy and abortion. They characterize abortion as a simple medical procedure which should be treated no differently from other medical procedures. Next, they portray pregnancy as a disease or disorder which, when it results in childbirth, is ten to twenty times more dangerous than abortion. They then suggest that because abortion on demand is allegedly safer than childbirth, it must remain legally available as a medical treatment or cure for pregnancy and childbirth.

In addition to this radical view of pregnancy, childbirth and abortion, petitioners present the Court with outlandish and unsubstantiated claims regarding: 1) the numbers of pre-*Roe* abortion deaths; 2) the impact of *Roe* on the safety of abortion; and 3) the fate of thousands of women who will "undeniably" be forced to seek "back-alley" and self-induced abortions which could result in their deaths if *Roe* is reversed.

Based on their myopic and outmoded view of the human reproduction process—which view focuses solely on the woman and ignores the unborn child's very existence—petitioners argue that *Roe* should not be reversed and claim that it "fairly accommodates the interests of the woman and the state."

Amici curiae, the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and the Association of Pro-Life Pediatricians (AAPLP), are two national organizations. The former is comprised of obstetricians and gynecologists (all of whom belong to ACOG); the latter of pediatric physicians (all of whom belong to the American Academy of Pediatrics (AAP)). Both are dedicated to reaffirming the unique value and dignity of individual human life at all stages of development. Both are pleased to note that, although the

American Medical Association (AMA) and the American Academy of Pediatrics (AAP) in the past have joined the ACOG in supporting *Roe* and abortion on demand, neither the AMA or the AAP has done so here.

Members of AAPLOG routinely treat the unborn child as a second patient in their obstetrical practices. The efforts that they undertake to care for, diagnose, and even treat the unborn child during the course of his or her development *in utero* underscore the incongruity of this Court's post-*Roe* abortion standards which wholly ignore the existence and rights of the unborn child prior to viability and, as a practical matter, do so to a large extent after viability as well.

Members of the AAPLP often treat premature infants who, under this Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), could have been aborted. Thus, they, like members of the AAPLOG, are often confronted in their practices with the inconsistencies of *Roe*.

Amici submit this brief to provide the Court with a better understanding of the true nature and risks of pregnancy, childbirth and abortion as they are viewed in modern obstetrical practice. *Amici* also submit this brief to correct many of the erroneous "medical facts" set forth in petitioners' brief and that of ACOG. It is hoped that this brief will help to persuade the Court of the errors of *Roe* and cause the Court to abandon the rigid trimester framework promulgated in *Roe*.[1] The abandonment of *Roe* would allow the states, once again, to protect the unborn, who cannot speak for themselves.

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1. *Amici* submit that the question of whether *Roe's* trimester framework should be reversed is properly before the Court. The questions presented ask whether the lower court erred in ruling upon the constitutionality of various abortion regulations. In rendering its decision, the lower court adopted an undue burden standard of review. Whether that standard or some other standard is the correct one to apply in deciding upon the constitutionality of abortion regulations necessarily depends upon whether the standard articulated in *Roe* remains valid.

SUMMARY OF THE ARGUMENT

In modern obstetrical practice, the physician treats two patients—the mother and the unborn child—and strives to maximize and protect the health and well-being of both. Good medical practice requires this. It is rare that the interests of one of these patients, from a medical standpoint, conflicts with the other. Thus, abortion is rarely medically indicated and the vast majority of abortions are performed for socio-economic reasons; not for medical reasons. Even in those instances where the mother's condition may place her physical health at greater risk, the pregnancy can generally be managed satisfactorily with a successful outcome for both the mother and baby.

Every abortion, if successful, results in the death of one patient—the unborn child. Thus, the performance of elective abortion violates the long-standing ethical obligation of physicians to "do no harm."

Roe's trimester framework does not fairly accommodate the state's compelling interests in protecting either unborn human life or maternal health. Rather, it uniformly places the socio-economic concerns of the mother, whether substantial or trivial, above the life of the unborn child. To the detriment of many women, *Roe* also unnecessarily restricts the ability of the states to regulate abortion on behalf of maternal health. For these reasons, *Roe* should be reversed.

The reversal of *Roe* would not result in any significant increase in maternal mortality or morbidity from abortion because *Roe* was not a major cause of reduced maternal mortality and morbidity from abortion. Such reductions correspond more closely with medical advances in areas such as pharmacology and medical technology which are wholly unrelated to the legalization of abortion. Reversal of *Roe* will not affect those advances, nor will it preclude the application of future medical advances to the treatment of women who might seek illegal abortions. Thus, even if, upon a reversal of

Roe, all states were to outlaw abortion except when necessary to preserve the mother's life (an extremely unlikely occurrence), it is unlikely that that event would result in any significant increase in maternal mortality or morbidity from abortion.

ARGUMENT

I. ROE'S TRIMESTER FRAMEWORK DID NOT "FAIRLY ACCOMMODATE" THE STATE'S INTERESTS IN PROTECTING UNBORN LIFE OR MATERNAL HEALTH.

Petitioners claim that *Roe's* trimester framework is workable, Pet. Br. at 27, and assert that "[d]uring the last nineteen years, lower courts . . . have had little difficulty in applying *Roe's* clear mandates." Pet. Br. at 30. Unfortunately, this appears to be true. No matter how reasonable the statute, those courts have determined, with fair consistency, that *Roe* requires that its enforcement be enjoined. Petitioners apparently believe that this "fairly accommodates the interest of the woman and the state." *Id.* at 15.

Amici strongly disagree with petitioners' view. Notably absent from petitioners' brief is any meaningful discussion of the state's legitimate interests in protecting the life of the unborn child and in protecting maternal health. Application of *Roe's* principles does not accommodate the state's interests in protecting either fetal life or maternal health. Indeed, *Roe* has left the unborn child virtually unprotected and unprotectable throughout the full nine months of pregnancy and has prevented the states from dealing effectively with serious public health problems associated with many abortion clinics, to the detriment of many women. Thus, *Roe* has not even served the interests of the women it was designed to protect.

A. The States Have a Compelling Interest in Protecting Unborn Life Throughout Pregnancy and *Roe* Unfairly Denigrated the Value of the State's Interest by Characterizing the Unborn as "Potential Life."

1. The basic facts of fetal development are well-known and were presented to the Court in *Roe v. Wade*, 410 U.S. 113, 156 (1973). The briefs submitted by the State of Texas in *Roe* set forth in great detail the facts of fetal development (with pictures) from conception forward, and we do not repeat them here. *See*, Brief of Appellee in *Roe*, No. 70-18 at pp. 29-54. The majority in *Roe* either disregarded these facts or failed to give them proper weight. As a consequence, the Court undervalued the state's interest in actual unborn life—recognizing it as an interest only in "potential" life. The *Roe* Court compounded this error by presuming that the state's interest in protecting that "potential" life is different at various stages in pregnancy. As Justice O'Connor noted in her dissent in *Akron v. Akron Center for Reproductive Health*, "[t]he difficulty with this analysis is clear: *potential* life is not less potential in the first weeks of pregnancy than it is at viability or afterward." 462 U.S. 416, 461 (1983) (emphasis in original).

What we know now about the unborn has dramatically increased our understanding of the humanity of the unborn child. This Court is urged to reacquaint itself with these facts and to reevaluate the compelling nature of the state's interest in protecting unborn life. For this reason, we take this opportunity to provide the Court with a few updated examples of what we now know of the unborn child within the womb. See this brief, *infra.*, at 6-11. We believe these facts will assist the Court in viewing the practice of obstetrics and abortion, not in the distorted manner presented by petitioners and ACOG, but rather, in the perspective of modern obstetrical medicine. It is also important to do this in order to provide the Court with a proper understanding of the

nature of the Commonwealth's interest in protecting the unborn child's life.

2. In enacting the Abortion Control Act, the Commonwealth of Pennsylvania asserted an interest in protecting "the life and health of the child subject to abortion." 18 Pa.C.S.A. §3202(a). It referred to this interest as "a supreme value in protecting human life." 18 Pa.C.S.A. §3202(b)(4). As such, the Commonwealth asserted a compelling interest in protecting the *actual* life of the unborn child; it did not assert an interest in protecting merely *potential* life.

3. Modern obstetrical medicine recognizes the unborn child as a patient. This recognition supports the compelling nature of the state's interest in protecting actual unborn life.

In focusing solely on the effect of pregnancy and abortion on the woman, petitioners have failed utterly to acknowledge the other patient routinely cared for in present day obstetrical practice—the unborn child. This omission is glaring when contrasted with statements found in *Williams Obstetrics*, traditionally one of the leading medical texts on obstetrical practice. In explaining the need for significant revisions in that text's 1980 edition, its authors stated:

> Happily, we have entered an era in which the fetus can be rightfully considered and treated as our second patient . . . Fetal diagnosis and therapy have now emerged as legitimate tools the obstetrician must possess. Moreover, the number of tools the obstetrician can employ to address the needs of the fetus increases each year . . . who would have dreamed—even a few years ago—that we could serve the fetus as physician? Or, that the well-being and growth of the fetus could be monitored accurately and that the status of fetal health could be addressed?

Pritchard & MacDonald, *Williams Obstetrics*, p.vii (16th Ed. 1980).

Abortion is a highly controversal issue precisely because of the existence of the unborn child who is subject to its destructive forces. If the medical procedure of abortion involved only the removal of a diseased organ of the woman and did not cause the destruction of a new and independent life, there would be no controversy. Thus, it is entirely inappropriate for pregnancy and abortion to be viewed strictly as medical conditions and procedures without reference to the unborn child.

The most current edition of *Williams Obstetrics* makes this clear:

> Obstetrics is *an unusual speciality of medicine.* Practitioners of this art and science must be concerned simultaneously with the lives and well-being of two persons; indeed, the lives of two who are interwoven.

Cunningham, MacDonald & Gant, *Williams Obstetrics*, vii (18th ed. 1989) (emphasis added). In a chapter entitled "Techniques to Evaluate Fetal Health," it is stated:

> Until relatively recently, the intrauterine sanctuary of the fetus was held to be inviolate. The mother was the patient to be cared for; the fetus was but another albeit transient, maternal organ. . . . Indeed, the fetus is no longer regarded as a maternal appendage ultimately to be shed at the whim of biological forces beyond control. Instead, the fetus has achieved the status of the second patient, a patient who usually faces much greater risks of serious morbidity and mortality than does the mother.
>
> * * *
>
> It is now possible not only to identify but to quantify with some precision physical abnormalities and functional derangements that afflict the fetus.

> Moreover, in some instances treatment can be implemented—surgical as well as medical—while the fetus continues to mature in utero.
>
> • • •
>
> The many advances in diagnosis and treatment that now clearly establish the fetus as a patient have also contributed remarkably to legal considerations involving the fetus. Fetal legal rights are emerging; for example, in some courts, the fetus has been allowed to file suit.

Id. at 277.

Roe erroneously viewed the state's interest as an interest in "potential" life; not actual life. Petitioners' and ACOG's continued use of the term "potential life" to describe the unborn child—as though there is no actual life within the womb—is confusing at best. Certainly this is a gross misuse of the English language. A common dictionary definition for "potential" is "existing in possibility: capable of development into actuality." *Webster's New Collegiate Dictionary*, 893 (1979). "Actuality" is defined as "the quality or state of being actual," and "actual" is, in turn, defined as "existing in fact or reality." *Id.* at 12.

There can be no question that the unborn child is actually alive and that abortion causes his or her death. If there were no actual life within the womb, there would be nothing to attempt to destroy through abortion and it would be meaningless to speak of "fetal death." Yet these concepts are routinely discussed in the medical literature.

A common method of abortion, used routinely up until the 24th week of pregnancy, and even thereafter by some,[2] is dilation and evacuation (D&E). This procedure involves the progressive dismemberment of the unborn

2. In *Planned Parenthood v. Ashcroft*, the Court noted that one doctor "supported the use of D&E on 28-week pregnancies, well into the third trimester." 462 U.S. 476, 483 n.7 (1983).

child within the womb followed by the removal of the child's body parts.[3] Although a D&E abortion is almost always fatal to the child, a recent report in *The New York Times* told of a baby girl who had survived an attempted abortion, albeit without one of her arms which was severed during the procedure. *The New York Times*, November 21, 1991, at B.1.

In describing how to perform a D&E procedure on unborn children with gestational ages of between 21 and 24 weeks,[4] Dr. Warren Hern states the following:

3. One advantage of D&E over instillation methods is that the woman does not have to "experience the expulsion of the fetus, which may or may not have signs of life." Hern, *Abortion Practice* at 133.

4. Although late-term abortions constitute only a small percentage of the approximately 1.5 million abortions that are legally performed annually in this country, given the sheer magnitude of the numbers, the actual number of such abortions is quite substantial. The Centers for Disease Control report that 1% of abortions are performed at 20 weeks or more. *Centers for Disease Control: Abortion Surveillance 1981*, p. iv, Summary Table (1985). This translates into approximately 15,000 per year, or about 290 per week.

There is no indication that late-term abortions are performed in large numbers for maternal health or because of fetal abnormalities. Dr. Hern states that the intent of his book is to discuss clinical abortion technique from 6-24 menstrual weeks gestation with emphasis "on outpatient practices in a freestanding clinic or private office setting." Hern, *Abortion Practice* at 102. If this is so, it is unlikely that he is performing such procedures on high-risk patients for whom they are medically indicated. Presumably, such patients would be cared for in a full service hospital. And, as Dr. Bolognese testified in this case, the method of choice for terminating a pregnancy in emergency circumstances is not D&E. Appendix at 613. Likewise, Planned Parenthood's research arm reports that only 2% of the women surveyed who had late-term abortions listed the diagnosis of a fetal problem as the reason for delay. Torres & Forrest, *Why Do Women Have Abortions?*, 20 Fam. Planning Perspectives 169, 174 (Table 4) (1988). We note that the reporting provisions of the Pennsylvania law would facilitate better reporting of such data and urge the Court to uphold that provision.

> The procedure changes significantly at 21 weeks because the fetal tissues become much more cohesive and difficult to dismember.
>
> * * *
>
> A long curved Mayo scissors may be necessary to decapitate and dismember the fetus. . .

W. Hern, *Abortion Practice* at 154. Although an injection of urea is usually given to cause fetal death before dismemberment is begun, the dismemberment apparently may take place when the fetus is still alive. "If fetal death has not occurred and labor has not begun, the operator may elect. . . to proceed with a D&E procedure under direct ultrasound visualization." *Id*. Presumably, the use of ultrasound assists the operator in locating the baby which may be attempting to escape the lethal instruments.[5] *See also,* Kerenyi & Chitkara, *Selective Birth in Twin Pregnancy With Discordancy for Down's Syndrome*, 304 New Eng. J. Med. 1525, 1525-26 (1981)(describing "active fetal movements and fetal heart rates of 140 to 150 beats per minute" in a fetus of 20 weeks gestation before the insertion of a needle into the fetal heart for the express purpose of extracting 25 ml of blood and thereby causing cessation of "cardiac activity").

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5. "Although the fetus starts making spontaneous movements at about seven weeks after conception, mothers do not usually feel their babies moving until about 16-21 weeks. *** The fetus needs to be heavily sedated by sedating the mother before intrauterine manipulations such as transfusions. Otherwise he will move away from the needle." Valman & Pearson, *What the Fetus Feels*, 1980 Brit. Med. J. 233, 234.

Likewise, if there were no "actual life" in the womb there would be no individual upon whom to: perform fetal surgery,[6] provide drug therapy,[7] conduct behavioral studies,[8] or take pictures.[9] Nor would there be any "baby" with whom mothers could bond. *See*, Fletcher & Evans, *Maternal Bonding in Early Fetal Ultrasound Examinations*, 308 New Eng. J. Med. 392 (1983). It has been reported that, when ultrasound examinations were performed on women in the late first or early second trimester of pregnancy, those women "reported feelings and thoughts clearly indicating a bond of loyalty toward the fetus." *Id*. at 392. In that same study, two women who were contemplating abortion were asked how they felt about seeing what was inside them. One stated: "It certainly makes you think twice about abortion! . . . I feel that it is human. . . . I couldn't have an abortion now." *Id*. The other stated: "It really made a difference to see that it was alive. . . . I am going all the way with the baby. I believe it is human." *Id*.

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6. It is now possible to perform surgery on the mother, partially extract the baby and perform surgery on it, and then return the baby to the womb to continue its development. Longaker, et.al., *Maternal Outcome After Open Fetal Surgery*, 265 J.A.M.A. 737, 740 (1991) (reporting on 17 such cases with "no maternal deaths and few serious complications").

7. Various drug therapies are now available to ameliorate fetal problems. *See e.g.*, Harrigan, et al, *Successful Treatment of Fetal Congestive Heart Failure Secondary to Tachycardia*, 304 New Eng. J. Med. 1527 (1981) (the administration of digoxin to the mother "when the fetal heart rate is persistently over 200 beats per minute can reduce the threat of fetal death and make the delivery of an immature infant unnecessary").

8. Kolata, *Studying Learning in the Womb*, 225 Science 302 (1984)(A relatively new body of data indicates that learning begins before birth. For example, the fact that the newborn immediately recognizes his or her mother's voice indicates that the baby can hear before birth. "This idea suggests a whole series of questions about how and when an unborn baby can learn.")

9. *See* L. Nilsson, *A Child is Born* (1990), which uses modern photographic techniques to capture the unborn child in "living color" within the womb.

4. From the foregoing, it is clear that Pennsylvania has asserted a compelling interest in protecting *actual* unborn life. If there were any doubt about the actual existence of the unborn child at the time of *Roe*, there can be none now. Modern obstetrical practice proves the actual existence of the child.

Several members of this Court have previously noted the error of *Roe* in failing to give proper deference to the state's interest in protecting the unborn and have indicated their view that the state's interest in protecting "potential" life should be recognized throughout pregnancy. *See, Akron v. Akron Center for Reproductive Health*, 462 U.S. at 461 (O'Connor, J., dissenting); *Webster v. Reproductive Health Services*, 492 U.S. 490, 519 (1989) (Rehnquist, White, Kennedy, J.J., plurality). However, a majority of the Court has never so held. *Amici* respectfully urge the Court to correct the illogic of *Roe* and hold that the states have a compelling interest in preserving the *actual* lives of unborn children.

B. The States Have a Compelling Interest in Protecting Maternal Health Throughout Pregnancy and *Roe* Unnecessarily Restricts the Ability of the States to Regulate on Behalf of That Interest.

Despite petitioners' claims to the contrary, *Roe* did not "fairly accommodate" the state's interest in preserving maternal health. The Seventh Circuit's decision in *Ragsdale v. Turnock*, 841 F.2d 1358 (7th Cir. 1988), is instructive. That case involved a challenge to the Illinois regulations governing ambulatory surgical facilities, including abortion clinics.

A brief recitation of the historical background surrounding the promulgation of those regulations gives a better understanding of the compelling nature of the state's interest. A five-month undercover investigation of numerous abortion clinics conducted in 1978 by the Better Government Association and the *Chicago Sun Times* had exposed widespread unsafe and unethical

practices in the abortion industry. *See*, Zeckman & Warrick, "The Abortion Profiteers," *Chicago Sun Times*, Dec. 3, 1978 (special reprint) lodged with the Brief *Amicus Curiae of Certain Illinois Senators and Representatives in Support of Appellants* and filed in this Court in *Turnock v. Ragsdale*, No. 88-790. The investigation showed that a number of abortion providers were profiting greatly at the expense of women—performing abortions on women who were not pregnant, operating under unsafe conditions and generally exploiting their patients.[10]

Against this backdrop and in direct response to this investigative series, the Illinois General Assembly conducted extensive hearings on the regulation of abortion clinic practices and of outpatient surgical procedures generally. 80th General Assembly, *Report to the House Human Resources Committee, Subcommittee on Health*, "State Regulation of Abortion Clinics," December 13, 1978.

According to the subcommittee report, stricter enforcement of existing regulations and the promulgation of additional regulations, designed to prevent abuses by requiring minimum licensing standards and on-site inspections, were deemed necessary to ensure that abortions would be performed safely and ethically in the state. Such regulations were deemed necessary because physicians were simply unable or unwilling to police themselves. Moreover, the state Medical Practice Act (MPA), which governed licensure of medical professionals and required that physicians performing abortions do so in licensed clinics, was not preventive in nature;

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10. Pamela Zeckman, who won a Pulitzer Prize for her reporting, concluded:

> In 1973, the Supreme Court legalized abortion. As it turns out, what they legalized in some clinics in Chicago is a highly profitable and very dangerous back-room abortion.

"Risky Abortions: Chicago clinics are exposed," *Time Magazine* (Nov. 27, 1978), 52.

rather, it operated primarily after the fact—once gross misconduct had already occurred.

In 1985, the regulations and MPA were challenged by Dr. Ragsdale as violative of both his right to perform early first and second trimester abortions without state interference and of his patients' rights to obtain such abortions. Dr. Ragsdale argued that a number of the restrictions had to be struck because they belabored the obvious and insulted the physician's integrity. He claimed the other regulations were unconstitutional because the state had not shown that they were "medically necessary."

The state argued that the regulations needed only to be reasonably related to maternal health to withstand constitutional challenge. Over the strong dissent of Judge Coffey, the majority of the Circuit panel rejected the state's argument and determined that the state had failed to meet its burden of proving that the regulations were medically necessary. *Ragsdale v. Turnock*, 841 F.2d 1358 (7th Cir. 1988). Accordingly, the majority held that the state's general regulations governing outpatient surgical centers, insofar as they related to the performance of first and early second trimester abortions, must be enjoined because they violated *Roe's* trimester framework. Thus, abortion clinics were held to be exempt from the minimal safety standards applicable to all ambulatory surgical facilities in the state.[11]

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11. A recent four year study by the Government Accounting Office of ambulatory care facilities noted the dramatic increase in the number of such facilities during the past decade. "Officials in 36 states told the GAO that more regulation was needed to insure patient safety and consumer protection." *Patient Safety and Consumer Protection Problems in Unlicensed or Undersupervised Ambulatory Care Facilities, Hearing Before the Subcommittee on Regulation, Business Opportunities and Energy of the House Committee on Small Businesses,* 102nd Congress, 1st Session 102-17 at p.2 (1991).

> Outpatient facilities can offer patients cheaper care, more convenience and greater privacy. But we have also found that too often, procedures performed in these clinics are conducted in spartan surgical settings with skeleton crews that are never inspected, nor subject to public accountability. Under such conditions, they are a refuge for the unqualified, the unscrupulous and the undertrained.

Id. at 74.

> This state of affairs is an open invitation to bad medicine. It has resulted in thousands of unnecessary or needlessly dangerous surgeries. It is the cause of countless patient injuries and deaths.

Id. at 78

From the earlier investigative series, it is clear that many abortion clinics exhibit these same characteristics; creating a refuge for abortionists who are unskilled and unethical. Regulations requiring that abortion clinics meet minimal safety standards applicable to other ambulatory surgical facilities are clearly reasonable.

Moreover, it should be obvious that a regulation which may not be "medically necessary" as it relates to the practice of one clinic (because that clinic can operate safely without it), may be necessary relative to another. Whatever the practices at the named clinics in this case, there is no assurance that other clinics within the state have similar practices. Indeed, we note that one clinic, Northeast Women's Center, withdrew from the litigation in the course of discovery.

Tragically, had those regulations been upheld by the federal courts, at least one more woman might not have died from a "safe" and "legal" abortion. Section 205.40 of the state regulations (which were held to be unenforceable under *Roe* by the Seventh Circuit) would have prohibited abortion clinics from requiring patients to "leave the center in less than one (1) hour following the procedures."

Dr. Arnold Bickham, one of the doctors exposed in the *Abortion Profiteers* series, was ultimately convicted of medicaid fraud in 1979 and sent to jail for two years. But Dr. Bickham was out and aborting women again by 1986. He was doing so despite the fact that he had lost his medical license for 18 months after the State had charged that he had performed abortions on patients whose pregnancy tests were negative and, in his haste to perform abortions on a high volume of patients (he was

paid per patient), had performed abortions on patients before the anesthesia had time to take effect. *Chicago Tribune*, Feb. 18, 1987, Section 2, p. 3. According to that *Tribune* article, a complaint filed against Dr. Bickham in 1986 charged that he was responsible for the death of a patient who bled to death hours after Dr. Bickham performed an abortion on her and "forced [her] to leave the clinic office while [she] was in shock and/or otherwise unable to care for herself." *Id.*

Thus, it may be true that the lower courts have consistently construed *Roe* to broadly prohibit any interference with the abortion industry. But this fact does not demonstrate that *Roe* should be reaffirmed. Rather, it shows precisely the opposite. Far from fairly accommodating the legitimate and compelling interests of the states in protecting maternal health and unborn life, *Roe* accommodates only the abortion industry.[12]

II. REVERSAL OF ROE WOULD NOT RESULT IN ANY SIGNIFICANT INCREASE IN MATERNAL MORTALITY FROM ABORTION.

In their zeal to defend *Roe* and abortion on demand, petitioners and ACOG present the Court with outmoded claims regarding pregnancy, childbirth and abortion. They portray pregnancy and childbirth as diseases and abortion as the cure. They also make invalid statistical comparisons between abortion and childbirth and claim that childbirth is ten to twenty times more dangerous than abortion. Thus, they misleadingly imply that childbirth is very dangerous. They further suggest that because abortion is "safer" than childbirth at all stages in pregnancy, it must be allowed on demand. Moreover, since they argue that it is impermissible to allow any

12. As is routinely the case, the plaintiffs in this litigation are abortion providers who have a great financial interest in the unfettered operation of their businesses to protect. There are no pregnant women plaintiffs in this action who claim that these provisions burden their individual rights.

"trade-off" of maternal health in an attempt to preserve fetal life, petitioners and ACOG argue in favor of abortion on demand throughout pregnancy.

This one-sided presentation does not accurately depict modern obstetrical practice and it should be disregarded by the Court.

Moreover, petitioners grossly exaggerate the number of maternal deaths from abortion prior to *Roe* and then erroneously suggest that *Roe* was the reason for a dramatic reduction in maternal mortality from abortion. In fact, however, maternal mortality from abortion (legal and illegal) had been decreasing steadily before *Roe* and continued to decrease thereafter. See Appendix to this brief. During those same time periods, maternal mortality from all causes also decreased steadily. *Id.* These decreases were due not to changes in the law, but rather, to medical advances in treating the complications of pregnancy and childbirth as well as those from abortion.

A. Pregnancy and Childbirth are Natural Occurrences which Carry with Them Very Little Risk to the Pregnant Woman in Ordinary Circumstances. Pregnancy is not a Disease which Must be Cured by Abortion.

1. Petitioners portray pregnancy and childbirth as diseases and suggest that abortion is its cure. Petitioners' Brief at 24-25. For example, they state that pregnancy causes a wide range of adverse health consequences for women. "As many as ninety percent of pregnant women develop gastrointestional problems, including nausea and vomiting." Pet. Br. at 24. And, "[o]ther common problems include back pain, varicose veins, hemorrhoids, headaches and water retention." *Id.* at n. 37. They then recount the risks of vaginal delivery in childbirth which entail "substantial risk of infection and laceration." *Id.* at 25. They also note that 25% of

women who deliver by cesarean section are exposed to higher risks of death.[13]

Petitioners' view of pregnancy as a disease rightly has been discredited by those in the mainstream of obstetrical practice. As a standard obstetrics textbook states:

> Pregnancy should be considered a *normal physiological state*. Unfortunately, the complexity of the functional and anatomical changes that accompany gestation tends *in the minds of some* to stigmatize normal pregnancy as a disease process.

Cunningham, et al., *Williams Obstetrics* at 257 (emphasis added).

Moreover, in presenting the Court with only the adverse consequences to the woman from pregnancy, petitioners tell only half the story. Once the woman is pregnant, only one of two outcomes is possible: childbirth or abortion. Abortion, like childbirth, carries with it a low incidence of mortality. However, it is not without risk and the possibility of major complication. In discussing the performance of abortion, Dr. Hern states:

> One of my more experienced colleagues recently commented, 'Abortion is a simple procedure except for the uterus's total intolerance to poor technique.'
>
> * * *
>
> In medical practice, there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion.

W. Hern, *Abortion Practice* at 101.

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13. At the same time, they fail to note the very low rate of maternal mortality from delivery by cesarean section. For example, Boston Hospital for Women recently reported a zero maternal mortality rate in 10,231 cases where a cesarean section was performed. Cunningham, MacDonald & Gant, *Williams Obstetrics* 443 (1989).

In recounting the risks of vaginal delivery, petitioners note that it carries substantial risk of infection and laceration. They fail to mention that all methods of abortion also carry with them a substantial risk of infection and laceration. *See generally*, Hern, *Abortion Practice* 175-206 (1984). (Major complications which are listed include: major unintended surgery such as hysterectomy, hemorrhage requiring transfusion, infection requiring hospitalization of 11 days or more, cardiac arrest, endotoxic shock, convulsion and death. Minor complications include: milder infections, uterine perforation, lacerations of the cervix and heavy bleeding.) Thus, once pregnant, neither abortion or childbirth is absolutely risk free.

Equally radical is petitioners' and ACOG's claim that the *failure* to permit a surgical intrusion into the woman's body through abortion subjects women to "significant intrusions of their bodily integrity." ACOG Br. at 10; Pet. Br. at 24-26. It strains logic to understand their position. Their references to cases involving surgical intrusions into the body to remove bullets and other objects for criminal investigations, Pet. Br. at 25-26; ACOG Br. at 10, are, for obvious reasons, wholly inapposite. Moreover, if they mean to suggest that the existence of the unborn child (or the pregnancy itself) is an "instrusion" into the woman's body, this is surely not something for which the state may be held responsible.

2. Petitioners and the ACOG also frequently discuss the statistical comparisons of risks of abortion and childbirth. *See,* Pet. Br. at 26 n.43, 32-33; ACOG Br. at 10. These comparisons and the resulting conclusion that abortion is statistically safer than childbirth at *all stages* of pregnancy, Pet. Br. at 32-33, appear to cause petitioners and ACOG to argue that abortion must be kept legal on demand throughout pregnancy.

Whatever the comparative risks of abortion and childbirth, such concerns are largely theoretical and irrelevant to a discussion of elective abortion. It is true that abortion is a medical procedure. Equally true,

however, is the fact that abortion is rarely a medical decision. It is almost universally a socio-economic decision.[14]

Since very few women decide to have abortions because they wish to avoid risks to their physical health, it is disingenuous to suggest that abortion must be kept available, on demand, due to the fact that it is statistically safer for women. This simply is not a consideration which informs their decisions.

This is not surprising when one considers the safety of childbirth and the ability of modern obstetrical medicine to satisfactorily manage most medical complications of pregnancy. To demonstrate the safety of childbirth, one need only consider the following. An average

14. This is particularly true of abortions performed in abortion clinics where the vast majority of abortions take place. Indeed, at least one physician has suggested that he would not perform an abortion if it were requested for medical reasons rather than for emotional or social reasons. In testimony before Judge James Kelly in *Northeast Women's Center, Inc. v. Michael McMonagle, et al.*, No. 85-4845 (E.D. Pa. 4/29/87), Dr. Klebanoff, a physician who routinely performed abortions at the clinic, testified as follows:
Q. Now doctor, take us through the procedures in a routine first trimester case. What is the first thing you do?
A. The first thing I do, is introduce myself. I ask the patient if they are having their operation for emotional reasons or not. . . .
Q. . . . Now, this emotional reason or not, what is that? Would you detail that a little bit more for us?
A. I ask the patient if they are having their operation due to emotional reasons.
Q. Is that the standard question that you ask?
A. I ask that in every patient, yes.
Q. What if the response is, "Yes?"
A. Then, I go ahead and proceed with the operation.
Q. That's the only question that you would ask the patient?
A. I ask them how they are and try to put them at ease.
THE COURT: What happens if they say, "No?" What happens if they say, "No, I am not having it for emotional reasons?"
THE WITNESS: If they say, "No," which I haven't run into yet, I expect I wouldn't do the procedure.
THE COURT: You haven't run into that yet?
THE WITNESS: No.

obstetrical practice may involve 180 deliveries per year. The maternal mortality rate for 1985 was 7.8 per 100,000. Centers for Disease Control: Morbidity & Mortality Weekly Report, Vol. 37 at 406 (1988). That means that the risk of death is .000078 per pregnancy, or 1 death per 12,500 deliveries. Given these circumstances, an obstetrician would have to practice roughly 70 years to encounter 1 maternal death. Indeed, as long ago as 1956, when maternal mortality rates were much higher, Dr. Alan F. Guttmacher, a strong supporter of abortion and the namesake of Planned Parenthood's Guttmacher Institute, stated:

> In more than 30 years of obstetrical practice, during which I have delivered something like 6,000 private patients, I have seen 3 of my own patients die, one from a fatal blood disease (leukemia at the 4th month), one from a clotting of a blood vessel in the brain several days after delivery, and one two weeks following birth of a recurrent breast cancer. Pregnancy and labor have little to do with any of the three. I do not recite these personal statistics boastfully, for they can be duplicated or improved upon by hundreds of doctors—probably by your own obstetrician—but their recitation must perforce be reassuring.

A. F. Guttmacher, *Pregnancy and Birth*, 271 (1956).

A number of obstetrical texts have also referred to the safety of childbirth and the lack of need to obtain abortions for medical reasons. For example, one such text states:

> The numbers of induced abortions performed annually in this country have been rising astronomically. Aside from those done 'on demand,' psychiatric indications are diminishing in number, while medical reasons appear to be almost vanishing. The continued decrease in the number performed for medical reasons is perhaps related to improved

> methods of managing the medical conditions indicated. Indeed medical therapy has improved so significantly that it is rare for organic disorders to be aggravated in properly managed pregnancies.

Greenhill and Friedman, *Biological Principles in Modern Practice of Obstetrics*, 385 (1974). *See also*, Reid, Ryan & Benirschke, *Principles in Management of Human Reproduction*, 274 (1972) ("abortion for purely medical reasons, i.e., vascular, renal or heart disease, and so forth, is rarely indicated in current medical practice.")

B. *Roe* Was Not a Major Cause of Reduced Maternal Mortality from Abortion.

In their brief, petitioners state: "In the 1950's and 1960's, an estimated 200,000 to 1.2 million illegal abortions occurred annually in the United States. As a result of these back-alley and self-induced abortions, as many as 5,000 to 10,000 women died each year and many other women suffered severe physical and psychological injury." Pet. Br. at 32. They then note that the maternal mortality rate for abortion is substantially lower today. *Id*. From these "facts," petitioners conclude that *Roe* and legalized abortion on demand are the cause of the dramatic reduction in maternal mortality. *Id*.

It is irreponsible for Petitioners to attempt to perpetuate such false statistics. In an article published in the *American Journal of Public Health* in 1960, Mary Calderone, M.D., then Medical Director of Planned Parenthood Federation of America, stated: "In 1957 there were only 260 deaths in the whole country attributed to abortions of any kind." Calderone, *Illegal Abortion as a Public Health Problem*, 50 Am.J.Pub.Health 948 (1960). Dr. Calderone noted that this number represented deaths attributable to both "therapeutic abortions" and "so-called illegal abortions." *Id*. Dr. Calderone also noted that there had been a dramatic decrease in abortion deaths in the past 30 years. "In New York City in 1921,

there were 144 abortion deaths, in 1951 there were only 15." *Id*. Dr. Calderone attributes the dramatic decrease in the abortion death rate to two corollary factors. "First, chemotherapy and antibiotics have come in, benefiting all surgical procedures as well as abortion. Second, and even more important, the conference estimated that 90% of all illegal abortions are presently being done by physicians." *Id*.

Dr. Calderone is not alone in her assessement of the situation. As long ago as 1967, Dr. Christopher Tietze, who was a medical statistician for the Population Council (a group strongly supporting legalized abortion), was quoted in an article in *The New York Times* as stating that only 247 deaths from illegal abortions were reported in the United States in 1964 and calling the same figures quoted by petitioners, here, "unmitigated nonsense." Graham, "Fetus Defects Pose Abortion Dilemma," *The New York Times*, September 7, 1967, at 38. *See also*, Tietze & Lewitt, *Abortion*, 220 Scientific American 21, 23 (1969) (figures "cannot be anywhere near the true rate"); B. N. Nathanson, M.D., *Aborting America* 193 (1979) (admitting that as co-founder of the National Abortion Rights Action League he and his organization knowingly falsified the number of "back-alley" abortion death statistics that they were claiming had occurred).

Many of the major risks for childbirth-associated maternal mortality are the same as those for abortion-related maternal mortality. These include: infection, hemorrhage, and complications from anesthesia. Tietze & Bongaarts, *The Demographic Effect of Induced Abortion*, 31 Obstet. & Gynecol. Survey 699, 708 (1976) ("Two of the major fatal complications of induced abortions are infection and hemorrhage which are also important causes of non-abortion maternal mortality."); Kaunitz, et al., *Causes of Maternal Mortality in the United States*, 65 Obstet. & Gynecol. 605 (1985). As noted in *Williams Obstetrics*, maternal deaths from all

causes had decreased remarkably in the past half century due to advances in medicine.

> Many factors and agencies are responsible for the dramatic fall in maternal death rate in this country over the past 50 years. Obviously there has been a general improvement in medical practice. The widespread use of blood transfusions and antibiotics and the maintenance of fluid, electrolyte, and acid-base balance in the serious complications of pregnancy and labor have materially changed obstetric practice. Equally important is the development of widespread obstetric training and education programs which have provided more and better qualified specialists.

Id. at 3. Thus, the medical advances in treating these problems necessarily relate to the reduction in mortality from both childbirth and abortion.[15]

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15. *See also, Human Life Federalism Amendment, Report of the Committee on the Judiciary United States Senate on Senate Joint Resolution 3*, 98th Congress, 1st Session, No. 98-149 at p. 40 (1983) (citations omitted) which states:

> As was noted in testimony before the House Judiciary Committee in 1976, maternal mortality from abortion has been decreasing steadily since 1942 at a rate comparable to that of maternal mortality from other causes. This drop in the maternal mortality rate seems due largely to improvements in medicine in general (*e.g.*, the development of antibiotics) as well as to improvements in maternal care in particular.
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> • • •
>
> In a new study on this matter, Hilgers and O'Hare have concluded that 'the legalization of abortion has had no effect on the already existing downward trend in the maternal mortality rate.'

The Senate report notes, however, that the incidence of non-fatal abortion complications appears to have increased "largely due to the sheer number of abortions performed. One major study of American hospitals reports that 35,000 women received treatment for abortion

Dr. Calderone noted that in 1957, 90% of illegal abortions were performed by physicians and attributes their relative safety to this fact and improvements in medicine generally. Calderone, *Illegal Abortion as a Public Health Problem*, 50 Am.J.Pub.Health at 949. *See also*, Tietze & Bongaarts, *The Demographic Effect of Induced Abortion*, 31 Obstet. & Gynecol. Survey 699, 708 (1976). In effect, then, the procedure, practice and safety of abortion changed little with its legalization. Instead, because of semantics, what were previously "illegal" abortions simply became "legal."

This fact does not suggest that, prior to *Roe*, illegal abortions were occurring at a rate anywhere near the 200,000 to 1.2 million figure claimed by petitioners.[16] Nor does it suggest that the legalization of abortion has had no impact on the number of abortions.[17] Likewise, it cannot be presumed that the prohibition of abortion would have no deterrent effect on the number of abortions. If abortion were made illegal, "couples and individuals would doubtless react by modifying their contra-

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complications at these hospitals in 1979, compared with 11,000 in 1969." *Id.*

16. It is impossible to determine, with any degree of accuracy, the number of illegal abortions which took place prior to *Roe* and petitioners' figures are guesses, at best. These figures must be grossly inaccurate, however, because they suggest that about twice as many women obtained abortions when it was illegal everywhere, than obtained abortions when it was legal on demand throughout the country. *Centers for Disease Control: Abortion Surveillance 1981*, 24, Table 1, (1985) (about 615,000 abortions were reported for 1973; only about 29,000 more than were reported in 1972 when abortion was illegal in 30 states except for life-threatening conditions.)

17. "The rate of increase in the number of legal abortions depends on how liberal the new law is and on its implementation." Tietze & Bongaarts, *supra*, at 704. "To the degree that unwanted births are replaced by legal abortions, the total number of induced abortions, legal and illegal, increases subsequent to legalization." *Id.* at 705.

ceptive and sexual behavior." Tietze & Bongaarts, *supra*, at 704.[18]

C. Reversal of *Roe* Will not Likely Return the States to their Pre-*Roe* Laws.

It should be remembered that prior to January 22, 1973, the 50 states were entitled to regulate or prohibit abortion in accordance with their views of what constituted wise public policy. They were free to weigh the interests of pregnant women against those of the unborn child. By the beginning of 1973, 20 states had liberalized their laws to allow abortion in various circumstances. (Though none had gone so far as required by *Roe*—allowing abortion throughout all nine months of pregnancy for any reason necessary to preserve the woman's emotional health, as broadly defined as in *Doe v. Bolton*, 410 U.S. 179, 192 (1973).) Thirty states continued, at the time of *Roe*, to prohibit abortion in all cases except where necessary to preserve the life of the woman.

The total number of abortions has dramatically increased in this country since *Roe* (an increase from about 615,000 abortions in 1973 to about 1.5 million today).[19] Petitioners assert that this increase indicates

18. The most current statistics from the Centers for Disease Control indicate that fully 40% of all abortions performed today are performed on women who have had at least one prior abortion. *Centers for Disease Control Abortion Surveillance, United States, 1988*, Vol. 40, No SS-1, Table 11. Thus, it would appear that a large percentage of women use abortion as a method of birth control.

19. It should be noted that the vast majority of abortions are performed at the seventh week of pregnancy or beyond; a time when both fetal heartbeat and brain waves are detectable. Although the Centers for Disease Control statistics show that just under 50% of all abortions are performed at eight weeks or less, this reporting scheme appears to be misleading. Approximately 94% of all abortions take place at the seventh week or beyond. Hern, *Abortion Practice* at 31 (Table 1-7). This is apparently true because complication rates for abortion are significantly greater at six weeks or less; particularly that of a continuing pregnancy which requires a repeat procedure. Testimony of Dr. Allen, Appendix at 532; Hern, *Abortion Practice* at 121. For this reason, the clinic personnel at the WHS clinic "discourage people from coming in for abortions before seven and a half weeks," and if the woman has already come to the clinic and is found to be too early in pregnancy, "that woman will be advised, if at all possible for her, to come back in two weeks for her procedure because the complication rate is lower." *Id.* at 533.

that abortion has become ingrained in the social fabric. Pet. Br. at 20. If petitioners are correct, it is exceedingly unlikely that anywhere near 30 states would return to their pre-*Roe* laws. In 1972, just prior to *Roe*, the Centers for Disease Control reported 39 abortion deaths from illegal abortions. *Centers for Disease Control: Abortion Surveillance 1981*, p.51, figure 8. Thus, even if we were to accept the assertion that *Roe* had a meaningful impact on reducing mortality from illegal abortions and that its reversal would put us back to conditions as they were in 1972, no greater number of women could be expected to die from any illegal abortions should *Roe* no longer control. But, given the significant and ongoing advances in treating the medical complications of pregnancy and abortion, and the fact that "legal" abortion will be more widely available than in 1972, the number of "illegal" abortion deaths which can be projected must necessarily be almost negligible. Accordingly, even if *Roe* were reversed there would be little, if any, increase in maternal mortality.

CONCLUSION

For the foregoing reasons, *Amici* respectfully request the Court to uphold the provisions of the Pennsylvania Abortion Control Act and in so doing, to reverse *Roe*.

Respectfully submitted,

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APPENDIX

APPENDIX

NUMBER OF MATERNAL DEATHS IN THE UNITED STATES, 1960-1978

Year	Total Number Maternal Deaths	Total Abortion Related Maternal Deaths	Total "Other" Maternal Deaths
1960	1,579	289	1,290
1961	1,573	324	1,249
1962	1,522	305	1,190
1963	1,416	280	1,186
1964	1,343	247	1,096
1965	1,189	235	954
1966	1,049	189	860
1967	987	160	827
1968	859	133	726
1969	801	132	669
1970	803	128	675
1971	668	99	569
1972	612	70	542
1973	477	36	441
1974	462	27	435
1975	403	27	376
1976	390	16	374
1977	373	20	353

Data from: Vital Statistics of the United States; Vol. II, Mortality, Part A, 1960-1977, Reproduced in Hilgers & O'Hare, "Abortion Related Maternal Mortality: An In-Depth Analysis" in *New Perspectives on Human Abortion*, 80, Table 7 (1981).